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EDITORIAL

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Reducing Social Isolation and Improving Quality of Life in Older Adults

Mithat Durak[1]

Welcome to the third issue of the JALTC in 2018. We are already excited to publish the last issue in 2018. In this issue, there are four new articles from different disciplines. Special thanks to all the authors who contributed to this issue.

First, to increase self-care independence among older adults, the importance of the partnership between staff and family caregivers is underlined. Based on qualitative depth interviews with staff, the cohesive collaboration with staff and dealing with negative family caregivers attitudes is mentioned. Caregivers empathy and compassion towards their job is discussed in the study.

Second, a new initiative for older adults about their continuing education is presented. This is the first university for older adults in the world and called "GeroAtlas60+Refresher University". This university for older adults is introduced by "lifelong learning" model that helps to gain new skills and competencies in different fields.

Third, whether satisfaction among older adults is affected by the place of residence is questioned. The variables related to satisfaction among older adults living at home and nursing home are discussed in the study. Researchers conducted quantitative research with older adults either living their home or in an institution. Building an enhanced environment (i.e., hobby, social activity, belonging to a house) among older adults living at home is emphasized for home satisfaction. Having personal decision about living in an institution, having a supportive social atmosphere (i.e., having visitors, visiting their family, having a hobby) is emphasized for institutional satisfaction.

Lastly, the quality of community services for older adults is examined. A cross-sectional survey is conducted among older adults living in a big city in Turkey to explore the quality of services in community centers. The higher ratio of participation in sports (i.e., walking) and social activities (i.e., with friends) are mentioned. Based on age and gender difference, higher sports activities among the 65-74 age group and women participants are also mentioned. The researcher emphasizes that the importance of community centers is mainly for older people living alone.

Those studies aforementioned above reveals the importance of quality of life in old age. The number of older individuals being isolated from society and waiting for the end of life with feelings of hopelessness should not be underestimated. Professionals working with older adults made attempts to deal with those problems that decrease their life quality (WHO, 2017). Those aspects remind us of how a supportive environment can be established for older adults. The answer can be given in twofold. The quality of life of the older people can be enhanced the first by the interventions within the community and the second by the arrangements offered by institutions.

Promoting older adult individuals to communicate effectively with each other and developing intergenerational activities in a society (i.e., older adults-children/adolescents, older adults- younger adults) are some examples of community interventions that will improve the quality of life. Workshops including participants in different age range can be arranged to increase communication between age groups. Those workshops can be conducted between local community centers and institutions. Besides, enhancing to participate in physical activities are essential for dealing with mobility loss problems (WHO, 2017). Regular physical activity not only keeps mental and physical health but also provides to reach socialization access as well as get rid of being inactive in daily life (Chodzko-Zajko et al., 2009).

Besides, familial support is necessary, especially in old age. The older adults who feel isolated and lonely have shorter lives and are at higher risk for dementia. Encouraging older adults to visit their family, relatives, and friends and having purpose-

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ful time with them will improve the quality of life. Older adults visiting their families at the outside of caring institute is related to higher satisfaction in a study (Durak & Senol-Durak, 2018).

Concerning institutional activities, improving the skills of nursing home staff about enhancing communication, arranging social activities within and at the outside of the institution would prevent social isolation among older adults. Those activities would improve the quality of life of older adults.

It is stated that the quality of life of older adults who are suffering from chronic diseases is low. The development of social support systems is an outstanding arrangement. In the societies where primary care is provided mostly by family members, the concepts of responsibility, love, and respect are essential. The social support from family members, friends, staff and significant others has a critical role for older adults who have to cope with chronic mental and physical illnesses.

In most societies, the most comprehensive, the most effective care institution appears to be a family. Strengthening ties between family members and making the family more dynamic and functional will enable older individuals to live a more peaceful and quality life. As mentioned the value of social support in declining cognitive aging (Seeman, Lusignolo, Albert, & Berkman, 2001) familial support is so important. On the other hand, increasing the number of nursing homes providing safe and clean atmosphere, mental and physical activity opportunities, and developing emotionally sensitive and respectful care are crucial in terms of quality of life of older people.

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Building a Cohesive Partnership: Perspectives of Staff Caregivers on Improving Self-Care Independence Among Older Adults Living in Long-Term Care Facilities

Su Hsien Chang[1] Ching-Len Yu[2] Mei-Chen Chen[3]

Abstract

This study was to understand how to establish a cohesive partnership aimed at improving self-care independence among older adults living in long-term care facilities. This was a qualitative research design. Results found that to build a partnership, staffs indicated three major elements are essential: (1) prior discussion, (2) building trust, and (3) reporting conditions of residents voluntarily. However, this study observed that *family caregivers' attitudes* and *health or characteristics of older adults* were of influence frequently affected older adults to regain/maintain self-care independence. To decrease the negative impact, the staffs should have attitudes of *compassion*, *empathy*, and *caring*.

Keywords: Self-care, aged, long-term care, caregivers, partnership

Key Practitioners Message

- To improve self-care independence of older adults in long-term care facilities, it is important to build a cohesive partnership between staff and family caregivers.
- Negative family caregivers' attitudes and health problems or negative characteristics of older adults could be negative impacts affecting older adults to regain or maintain self-care independence.
- To reduce the negative impacts, staff caregivers should have compassion, empathy, and caring.
- A solid partnership should be established between staffs and family caregivers.

Self-care abilities have special meaning as a way for older adults living in long-term care facilities to show independence. Cramm and colleagues (2012) indicated that older adults' self-management abilities were stronger indicators of well-being. Similarly, Chang (2009) studied beliefs of nursing home staff and residents about self-care. The findings showed that staff caregivers perceived being independent for residents living in a nursing home increase the adult's self-esteem, self-confidence, and maintain physical function. Residents perceived that being independence make them feel happy. Chang and colleagues (2010) also suggested that improving activities of daily living performance can result in enhancing life satisfaction and self-esteem among nursing home older adults in Taiwan. In brief, it is important for older adults to perform self-care independently.

Entering a long-term care facility constitutes one of the most difficult challenges to performing independent self-care among older adults. Although the current trend indicates that staff caregivers in long-term care facilities encourage elderly residents to continue performing independent self-care as possible (Askerud & Conder, 2016), however, due to various factors

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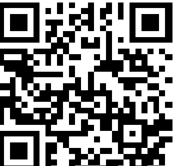

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including physical limitations, pain, depressed emotions, and family members and /or staff caregivers fostered dependency, older adults living in long-term care facilities seldom engage in independent self-care (Chang & Yu, 2013). Beedholm and colleagues (2016) conducted a qualitative study to understand what was at stake when a robot bathtub was implemented in a Danish older adults center. Data included interviews, participant observations, working documents, and media coverage. Results found that a robot bathtub for the bathing of the older adults resulted in two problems; 1) it is offensive to older adults integrity, damaging to their well-being, and 2) it also caused the staff physically strenuous. Chang (2009) also interviewed 10 residents and 10 staff caregivers of nursing homes to understand their beliefs about self-care. Findings showed that staff caregivers perceived they discouraged older adults in nursing homes to perform self-care because of staff shortage and family members supporting dependency. In contrast, receiving support from family and staff members facilitate older adults' motivation to regain self-care ability. Thus, staff caregivers constitute an important factor affecting older adults' behavioral dependency in self-care performance.

Although staff caregivers are taught to encourage older adults living in long-term care facilities to perform self-care independently, not every staff caregiver can follow and execute this notion. For example, Sacco-Peterson and Borell (2004) employed an ethnographic design using both qualitative and quantitative methods to understand why nursing home residents struggle with autonomy in self-care. Data collection involved more than 200 hours of fieldwork. Results showed that staff caregivers' conceptualizations of their responsibilities might lead them to assist residents in maintaining autonomy in self-care performance. Value-laden statements of staff caregivers, such as "she is a quiet woman… she never bothers anybody", indicate ways in which staff caregivers unknowingly encourage older adults to perform self-care independently. Change and Yu (2013) also investigated the perspectives of family caregivers about self-care independence among older adults living in long-term care facilities. Using a qualitative approach, data was collected via face to face interviews with 44 family caregivers. Results showed family caregivers perceived that high turnover rates caused negative impacts in re-constructing self-care independence, but guiding self-care performance can result in re-constructing self-care independence among older adults living in long-term care facilities. Therefore, staff caregivers in long-term care facilities play an essential role in maintaining the self-care independence of older adults. Few studies have focused on staff caregivers how they should conduct about improving the self-care independence among older adults living in long-term care facilities. This, the purpose of this study was to understand how to establish a cohesive partnership among staff, family caregivers and the facility administration.

Methods

This study used a qualitative design to explore the role of the staff caregivers on building a partnership aimed at improving self-care independence among older adults living in long-term care facilities. The data was collected via 31 in-depth qualitative interviews with staff caregivers, who were working in several long-term care facilities in Taiwan. This study was approved by the Human Subject Protection Program at the Chung Hwa University of Medical Technology.

Population and Sample

Participants were recruited from long-term care facilities located in southern Taiwan. Thirty-one staff caregivers were selected using the purposive sampling method. Subjects selection criteria were: 1) staff caregivers of long-term care facilities, 2) caregivers working in a long-term care facility for 6 months or more, 3) caregivers providing direct care to residents, and 4) caregivers willing to be tape-recorded during interviews.

Data Collection and Analysis

The face-to-face, in-depth interviews were conducted to collect data. In-depth interview data were collected through the process of

dialogue between the principal investigator (PI) and staff caregivers. Rich texture, details, and person-center narrative data were simultaneously collected. Each interview began with an open-ended question: "what has been your experience of working with residents' families in improving residents' self-care ability?" It was followed by the questions that attempted to clarify the causal nexus for staff. Moreover, each interview was conducted by the PI in a private, quiet, and comfortable room individually for 60 to 90 minutes. All interviews were audio tape-recorded, then, were transcribed verbatim for analysis. Each interview transcripts were recorded as a respondent code and did not include subject identification.

Verbatim transcripts of the interviews were analyzed using content analysis. This study used three-step data analysis (Guba & Lincoln, 1989). This process was repeated for each interview. First, the data was disaggregated into the smallest units. Next, these units of information were developed into tentative codes. Finally, the meaningful and accurate categories were sorted and generated.

Results

Participant Demographic Information

Thirty-one staff caregivers in long-term care facilities participated in this study. The majority of them were female (n = 29) and nursing assistants (n = 19). The average age was 43.59 years old (SD = 10.43), and the average working period was 69.13 months (Minimum = 4¸Maximum = 60.13) (see Table-1).

Table-1. Demographic information of study subjects

Variable	N (%)	Mean (SD)
Gender		
Female	29 (93.5%)	
Male	2 (6.5%)	
Occupation		
Nurses (Major Caregiver)	12 (38.7%)	
Nursing Assistant (No-Major Caregiver)	19 (61.3%)	
Age		43.58 (10.43)
Months of working		69.13 (53.43)

Study Findings

Results of the study found that building a cohesive partnership is an important way to improve self-care independence among older adults living in long-term care facilities (see Figure-1). The partnership connects between staff and family caregivers. Staff caregivers indicated three major elements are essential to construct the cohesive partnership: (1) *prior discussion*, (2) *building trust*, and (3) *reporting conditions of residents voluntarily*.

Staff caregivers perceived that: *based on prior discussions, staff can receive support from family caregivers in improving the self-care independence of older adults.* A staff caregiver indicated that "…We discussed with older adults and their families (how to improve or maintain the older adults independence). Actually, most family caregivers have been very supportive (for older adults to maintain and improve self-care independence). (#9)" Another staff said: "…the most important (for improving self-care independence) is prior discussions (with older adults' families) …if family caregivers are very aggressive and supportive (in improving self-care independence of older adults), we will act the same way. (#16)"

Staff caregivers perceived that *building trusting relationships with family caregivers is one way to enhance their support in improving the self-care independence of older adults*. One staff caregiver indicated that "…I encouraged older adults to self-feed…. they (family caregivers) support whatever I do for older adults because they (family caregivers) trust me… (#15)". Another

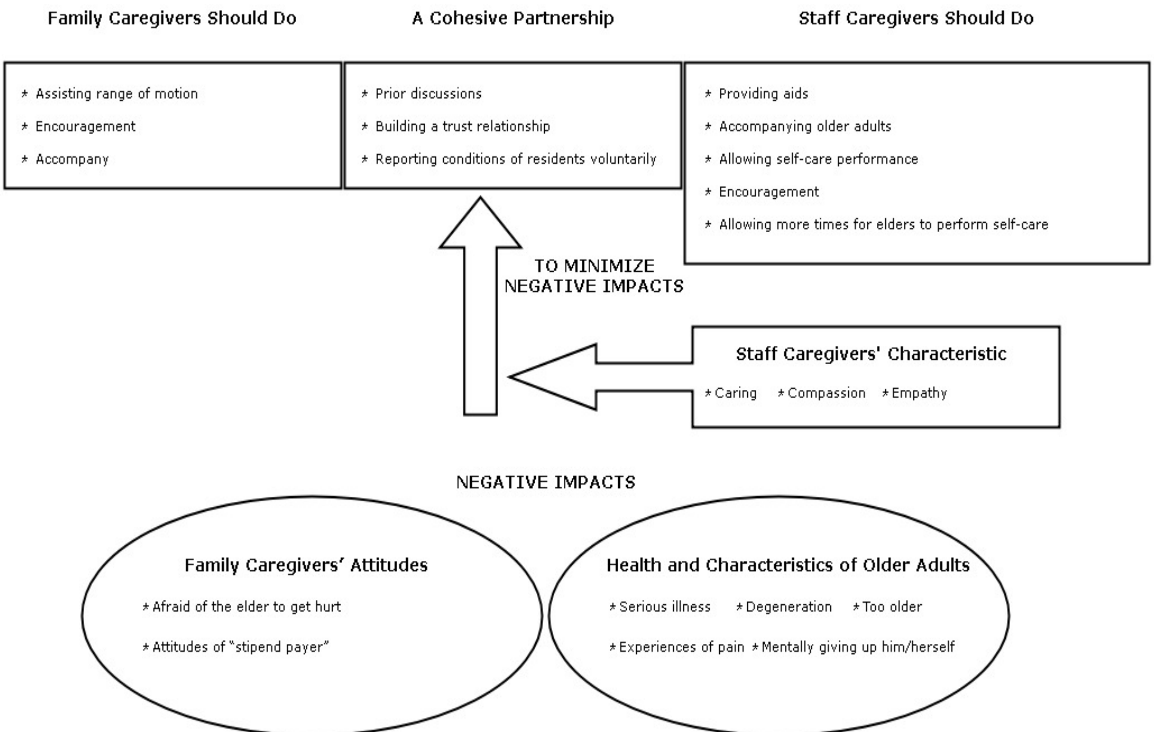

Figure-1. Perspective of staff caregiver on building a cohesive partnership aimed at improving self-care independence among older adults living in long-term care facilities

staff caregiver indicated the "…lack of trust from family caregivers; we (staff caregivers) receive no support (in improving self-care independence of older adults) … (#22)"

Staff caregivers should *report conditions of residents voluntarily, without family caregivers asking*. Staff caregivers said: "…if we (staff caregivers) report older adults' conditions voluntarily, without (family caregivers) asking, then, asking for their agreement, they become more supportive in allowing older adults to perform self-care independence…(#30)"; " …we should allow older adults to perform self-care, …it is one of the ways to assist them (older adults)…. we also should report older adults' conditions to them (family caregivers); then they (family caregivers) will provide support and encourage older adults to perform self-care….(#31)"

Family caregivers should do for older adults

Results also revealed that family caregivers can construct when they visiting older adults, including; 1) assisting in promoting the range of motion of older adults and 2) accompanying and 3) encouraging older adults as well. For instance, staff caregivers indicated that "…to improve older adults' self-care performance, when they (family caregivers) visit the facility, they (family caregivers) should accompany them (older adults), talk to them (older adults) and assist them (older adults) to do various activities… (#1)"; "… (to improve confidence in improving self-care independence among older adults) … family caregivers should accompany them (older adults) during meal time, …and provide encouragement… (#18)"

Staff caregivers should do for older adults

Staff caregivers perceived a number of things that they can contribute facilitate in improving self-care independence among older adults, including; 1) providing aids, 2) accompanying older adults, 3) allowing self-care performance, 4) encouragement and 5) allowing more time to perform self-care. Several staff caregivers gave examples: "… we (staff caregivers) have to accompany older adults, …allow self-feeding, …

we also need to pay a lot of attention when training older adults to self-feed…. (#3)";" … allow older adults to do self-feeding. We (staff caregivers) provide little assistance. …we (staff caregivers) also use aids or equipments, and allow them (older adults) to have more time to practice self-feeding… (#18)";" …we (staff caregivers) guide her (an older adult) to do self-feeding…we always tell her to slow down (each self-feeding step) …. we don't push her… (#30)"

Factors have a negative impact on older adults to regain or maintain self-care independence

Two factors were frequently observed having a negative impact: *family caregivers' attitudes* and *health or characteristics of older adults*. Staff caregivers perceived that *faulty perceptions of family caregivers* delay older adults in regaining self-care performance, including afraid of older adults to get hurt and attitudes of "stipend payer". For example, staff caregivers indicated that "…he can do self-bathing, but they (family caregivers) ask us (staff caregivers) to do it for him (an older adult). …they (family caregivers) are afraid (an older adult) will fall and get hurt. …they (family caregivers) love him (an older adult) too much. …. some family caregivers perceived that they spend a lot of money here (the long-term care facility). We have to do it for him (an older adult) and he should be treated as a boss…. (#24)"; "… they (family caregivers) think that they spend a lot of money per month. We (staff caregivers) should provide good services (to older adults). So, we have to feed him (an older adult) … (#25)". These attitudes obviously also have a notably negative impact on the partnership.

Staff caregivers also perceived that *health or characteristics of older adults* impacted staff and family caregivers' beliefs in improving self-care performance among older adults living in long-term care facilities. They mentioned the following characteristics: 1) too old, 2) serious illness, 3) degeneration, 4) lack of motivation, 5) pain and 6) mentally giving up on themselves. For example, staff caregivers indicated that "… based on the no harm principle, we allow older adults to do self-care. However, some older adults have no intention to do (self-care) due to their characteristics, such as being too lazy, being too old, and degeneration. Some older adults believe that it was not necessary for them to work too hard. They usually lie on the bed or sit on the chair and watch TV, but asking for assistance (in performing self-care) …. (#2)";" …due to illness, such as stroke, dementia, …older adults' self-care performances are affected… (#11)"; "…pain, degeneration, older adults are unable to perform self-care… (#14)". In addition, due to *staff shortages*, staff caregivers are unable to encourage or allow older adults to perform self-care independently. For instance, staff caregivers said that, "the staff shortage problem should be solved; otherwise, it is hard to improve (older adults) self-care abilities… (#21)".

Staff caregivers' characteristics can minimize the negative impact

To decrease the negative impact staff caregivers should have attitudes of *compassion*, *empathy*, and *caring* when they are taking care of older adults. Staff caregivers indicated that "…we provide positive encouragement. That can stimulate him (an older adult) to do (self-care). …I also feel that caring and empathy are important (for improving older adults; self-care independence) … (#6)"; "When we take time to or accompany them (older adults), they experience caring. They may feel that they are not abandoned due to being older…. Then, we (staff caregivers) should provide encouragement (on maintaining self-care independence) …. Doing these things might help older adults to maintain self-care performance (#27)".

Discussion

To establish a solid partnership aimed at improving self-care independence among older adults living in long-term care facilities, "trust", "prior discussion", and "initiative to confirm older adults' condition" are essential elements. The present findings are in accordance with previous studies. In a healthcare environment, trust is fundamental to all helping relationships (Clair, Beatty, & MacLean, 2005). The published report indicates that communication is a major tool for health care providers in improving health

care services (Jones, Postges, & Brimicombe, 2016). With trusting relationships and successful communication, health care providers can take responsibility for the care that clients need. Hence, Change and Yu (2013) investigated 44 family caregivers to understand their perspectives on re-constructing self-care independence among older adults living in long-term care facilities. The results showed that setting goals, building trusting relationships and routinely reporting older adults' conditions to families were the major elements for older adults re-constructing self-care independence.

The results of this study also found that care facilities for family caregivers and staff caregivers have the same goals for improving self-care independence among older adults living in long-term care facilities. In a previous study, Chang (2009) investigated beliefs about self-care among 10 nursing home staff caregivers and 10 older adults. The results showed that two factors that allow older adults to regain self-care ability include receiving support from family members, when they gave older adults praise, and receiving support from staff members when they encouraged and allowed older adults to perform self-care. Similarly, Weman and colleagues (2004) investigated 210 registered nurses to understand their views about their working performance and co-operation with family members in nursing homes and community care facilities. The results showed that all of the registered nurses expressed that co-operation between themselves and family members is important in their working performance. Results also showed that registered nurses believed it is important for family members to show engagement in caring for older people. Moreover, when older adults receive support from staff and family caregivers, older adults living in long-term care facilities will have stronger motivation in improving self-care independence.

The present results have also pointed several factors inhibiting self-care independence among older adults living in long-term care facilities. The factors include attitudes of family caregivers, older adults' characteristics, and staff shortages, which are consistent with those of previous studies (Chang, 2009; Chan, et al., 2011; Chang & Yu, 2013). For instance, Chan and colleagues (2011) reported that older adults with physical illnesses are more likely to experience a decline in functional abilities. Chang (2009) also indicated staff caregivers often do not allow older adults to do things for themselves because of time and staff constraints. In addition, Change and Yu (2013) indicated older adults' characteristics, such as degeneration, pain, laziness, and stubbornness, might lead to declining self-care independence. However, these negative impacts can be minimized, if staff caregivers show compassion, empathy, and caring attitudes, they can help to improve self-care independence among older adults living in long-term care facilities.

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Conclusion

To establish a solid partnership aimed at improving self-care independence among older adults living in long-term care facilities, staff caregivers perceived that it is important for staff and family caregivers to work together. Although a few factors have negative impacts, with compassion,

empathy, and caring attitudes of staff caregivers, older adults might regain or improve self-care independence. This study provides important information on how staff and family caregivers should work together to improve residents' self-care ability. In addition, psychoeducation programs for family and staff caregivers, and planning routine interviews conducted between family and staff caregivers can be organized to build a trustworthy relationship. Hence, how to deal with barriers and strength facilitator should be considered as an important issue by health care workers and policy makers. If older adults are able to perform independent self-care, the costs of care may be decreased because fewer nursing staffs are needed. The financial burden of residents' family members and the Taiwanese government would also be decreased as a consequence. Finally, older adults' quality of life would increase along with their ability to achieve conform with nature, allowing them to enhance health and wellness.

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The Effect of GeroAtlas60+ Refresher University in Preserving Individual and Community Health

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Melike Tamer Kose[4] Martin Pallauf[5] Eva Schulc[5]

Abstract

GeroAtlas60 + Refresher University is Turkey's first university for older adults based on theoretical assumptions and concepts. The University was founded as a response from the field of gerontology to support modern society's expectation for longer and healthier lives. If the quality of life is defined as older adults' feeling good about themselves in old age or until the end of their lives despite their physical, psychological, and social problems, one of the first questions that arise is how to provide this quality of life. GeroAtlas60 + Refresher University is a gerontological approach to this objective using a 'lifelong learning' model. The two-dimensional theoretical and practical curriculum provides older adults with knowledge related to their needs and also helps both genders to acquire new skills and competences such as participation in cooking and knitting courses by males and study of home improvement and Do-it-Yourself (DIY) home repair and maintenance courses by females. Activating older adults' knowledge and skills in the mental, physical, and social realms offers the potential for enhancing the quality of life outcomes.

Keywords: Learning, health, disease, aging, old age, older adults, rational action theory

Introduction

Both the number and proportion of older adults in the Turkish population are rising rapidly (TÜİK 2000, 2005, 2010, 2015). It is a general belief that, compared to modern times, the older adults enjoyed greater social value and respect in the past, were better provided and cared for by the 'extended family' but cannot be supported by the increasingly common nuclear family at the same level anymore (Sporbeck-Hörning, 1996; DPT, 2007)

However, there are findings that contradict this view and clearly show that nuclear families do not leave their older members in need (Tufan 2007, 2015, 2016a, 2016b). Modern society, which not only supports and cares for older adults but also recognizes them as individuals of equal value, is in favor of creating new opportunities for older adults involvement in new learning opportunities that did not exist in the past.

One such opportunity is Turkey's first university for older adults, GeroAtlas60+Refresher University, which was founded in 2016 in the Akdeniz University Gerontology Department through the cooperation of Akdeniz University, the National Society for Social and Applied Gerontology, and the National Council on Aging. Following Akdeniz University in Antalya; Ege University in Izmir, Sıtkı Koçman University in Muğla, Nişantası University in İstanbul and HEP University in Alanya have opened Refreshing University and the student count has almost reached 2000.

GeroAtlas60+Refresher University represents an important product of the Turkish Gerontology At-

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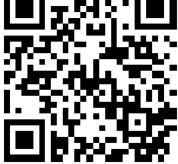

las (GeroAtlas) research project and is based on the lifelong learning model which opens up opportunities for older adults to acquire theoretical and practical knowledge and skills, thereby promoting their wellbeing. The GeroAtlas60+University in Turkey is more commonly known in other countries as the University of the Third Age (U3A) (Laslett, 1996).

The Healthcare Industry and the Concepts of Health and Disease

Pharmaceuticals and healthcare products have become a major industry. Jordan and Enderle (2004) reported that pharmacies in Switzerland carry 7.500 different medications and health products and that 4.000 to 5.000 different health products are sold in the private sector. There is also fierce competition within the markets for health products.

The number of professional groups in the health field is also growing rapidly. A health care professional and physiotherapy are among the most preferred health professions (Flury, 2004).

Medical advances and innovations will also contribute to the development of the healthcare system in the future. Current medical advances are primarily seen in the areas of biologic and chemical agents, surgical and medical devices, imaging and radiation methods, information technology, robotics, and home care (Häussler, Paquet, & Preuß, 2004). The motive for these advancements in the health sector is that health is recognized as our most precious commodity today. Although the experts agree on this, it is still difficult to define 'health'.

The well-known saying "Health is not everything, but without health, everything else is nothing" evokes our understanding of health. However, according to the philosopher Gadamer (1993), it is impossible for someone with no health problems to say what health is; only when sickness prevails can one conceptualize the true meaning of health.

Between 50 and 70 billion cells die every day. Approximately 120.000 copy errors occur in the cell division cycle per day, yet the human organism, which comprises about 220 different cell and tissue types, works perfectly (Schaal, Kunsch, & Kunsch, 2016). However, working perfectly does not mean never getting sick.

The World Health Organization (WHO) defines health as being completely free of physical, emotional, and social limitations. Unfortunately, lack of knowledge and misunderstandings relating to health and wellbeing often prevent older people from realizing their creativity in terms of generating health when they become unwell (Kruse & Wahl, 2010).

The concept of health has different meanings depending on one's perspective. From the .biomedical perspective, health is determined by a range of laboratory-based tests relating to human performance and overall function. In the context of functionality, it is described as the ability to fulfill social roles, respond to productivity demands, and adapt to changing situations. From the idealist perspective, health is considered the optimal balance between the physical, emotional, social, mental, and spiritual dimensions. Subjectively, it is described in terms of an individual's perceptions of health and disease. Health is defined as an energy store that allows individuals to reach the goals they consider important in life (Somaini, 2004).

Is the definition of disease, then, a lack of the factors considered in these perspectives? Does disease mean having laboratory values and function test results that deviate from average standard values in the biomedical approach; inability to fulfill social roles and performance expectations according to the functional approach; a perceived imbalance in the dimensions involved in the idealist approach; or insufficient energy to accomplish individual goals according to the subjective approach? Giving cursory answers to these questions or favoring one view over the others are not appropriate solutions because the relative significance of these four different dimensions varies according to the situation. For example, if laboratory values deviate from normal, no one will make the mistake of ignoring it. These perspectives all provide equally valid definitions of health which may be preferable in different situations and contexts.

Health and Disease in Older Adults

The risk of disease increases with advancing age. While younger individuals are primarily affected by acute diseases, chronic diseases become prominent in older patients. Alzheimer's disease, which is one of the most publicly recognized age-related health problems, is steadily becoming common (Tufan, 2016b). Psychological conditions other than Alzheimer's disease become more prevalent in old age. In addition to these, respiratory and vascular diseases are also more common (Tufan, 2007).

Care and support services are gaining importance as a result of shifting demographic distribution. A large portion of these care and support services are provided at private residences by private individuals within the family and kinship system (Meyer & Zumbrunn, 2004).

The need for care is mostly concentrated in the 80-plus group. This age group, referred to as the 'old old', forms the peak of the population age pyramid and is currently the fastest growing segment of the population. One of the repercussions of this population age shift may be an increase in healthcare expenses (Tufan, 2007). Therefore, maintaining the quality of life, increasing health, and enabling everyone to benefit from health services are accepted as the primary objectives of public health initiatives. Quality of life is defined as a having three dimensions: status, belonging, and future. Physical, psychic, and spiritual aspects comprise the status dimension; social context, community, and environmental aspects form the belonging dimension; and individual development, leisure time, and work comprise the future dimension (Somaini, 2004).

Learning and Its Contribution to Maintaining Health in Old Age

The main characteristics of learning are change and experience. Bower and Hilgard (1981) stated that Learning is related to behavior change or an individual's behavior potential in a certain situation based on repeated experiences with that situation (cited in Weidenmann 1995). By another definition, learning is "long-term change in behavior potential based on previous experience" (Ostermann, 2002). From this point of view, the behavior potential of these older students is the result of previous learning processes experienced before they start their education in the GeroAtlas60+Refresher University. The engagement of older people in the GeroAtlas60+Refresher University supports the potential for positive behavior change in a rational way, thereby assisting students to affect change through new learning experiences that become long-lasting"

The model on which GeroAtlas60+Refresher University operates is based on the rational action theory (Braun & Gautschi, 2011; Kunz, 1997). This theory, included in methodological individualism, focuses on macro and micro planes. The 'Coleman force' model emphasizes the importance of individual actions and transitions between the macro and micro planes in explaining social reality (Hirschle, 2015). Accordingly, in the macro (community) plane of the GeroAtlas60+Refresher University model, an individual's preexisting health-maintaining behavior potential is referred to as the social reality (a co-requisite of the model). The objective is to turn this potential into positive

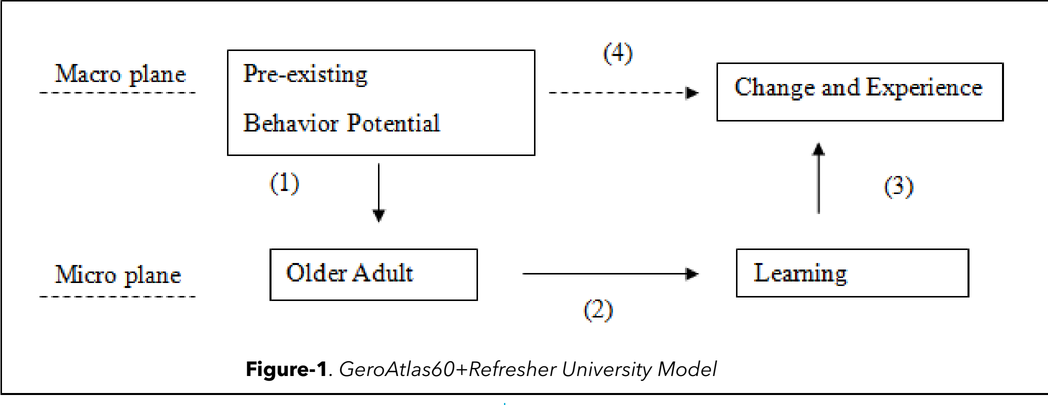

Figure-1. *GeroAtlas60+Refresher University Model*

and realistic change and to propel it to a higher level by providing new and meaningful experiences. However, according to social action theory, it is not possible to reach this goal directly. Therefore, it is necessary to first descend to the micro plane (individual or actor) for the purpose of inducing positive behavior change in the individual (learning or action). Figure-1 shows that by following paths 1, 2, and 3, changes are made at the individual level through the acquisition of new experiences and knowledge which in turn can impact the macro plane which involves the wider community. In this way, the 'learning activities' performed by the actor (the older adults) in the micro plane have the potential to impact the macro plane thereby helping to improve the health of the wider community.

Conclusion

The learning potential of older adults is a social reality. Durkheim's scientific notion of social reality is accepted as a form of reality beyond individual social beings, arising from the sum of individual behaviors, yet unique and independent of the individual. Community health is another social reality. GeroAtlas60+Refresher University consolidates these two social realities in the context of aging and creates changes in health behavior by affecting learning potential, thus facilitating change in the social reality known as community health.

While Durkheim focuses on social reality, methodological individualism focuses on the individual (Hirschle, 2015). Therefore, one's perspective comes to the fore. The GeroAtlas60+Refresher University model is an educational model which is based on methodological individualism that is aimed at older adults; that is, it focuses on the individual and the actions of the individual. In this model, the individual changes through engagement with new learning experiences and understandings which assist in the health of the individual but also provide an important opportunity to create positive health-related changes in the community. It must be understood that it is never too late to learn. Indeed, the older adult education movement reflected in the GeroAtlas60+ Refresher University contributes to the ongoing development of a *'learning society'* in Turkey. In a very important way, older adult learning can take many forms one of which is to develop the level of health literacy among older individuals which can lead to better health and quality of life (Nutbeam, 2000). Mason and Randell (1997) provide a clear message on the matter of relevancy for the provision of older adult learning opportunities that promote active and ongoing citizenship:

> *A new education for older people will have to be more than just recreation, information, and remediation, important though these aspects will continue to be. Education will need to address issues of personal and social transformation, vocational for older people and mechanisms for continued engagement in a society that will continue to place demands on their ability to adjust and survive. (p. 24).*

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The Characteristics and Life Preferences of Turkish Older Adults

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Abstract

The older adult population have been increasing around the World. The interaction of older adults with their physical and social environment is so important to promote age-friendly societies. In the present study, it is aimed to explore variables associated with satisfaction among older adults living at home and nursing home. Participants were composed of 1770 older adults living at home (N= 846) and nursing home (N=924). Results revealed that, regarding variables associated with home satisfaction, older adults having at least a hobby, participating in social activities, living with her/his spouse and living at a home belongs to her/himself or spouse had higher scores of satisfaction than their counterparts. Regarding variables associated with nursing home satisfaction, older adults referred to a nursing home by herself/himself, older adults having visitors (a family member or another person rather than a relative) at a nursing home, older adults visiting her/his family and older adults having at least a hobby had higher satisfaction scores than counterparts. Results were discussed with the literature and clinical implications.

Keywords: Older adults living at home, older adults living at the nursing home, home satisfaction, nursing home satisfaction, living place, participating in social activities, hobbies.

Key Practitioners Message

- The interaction of older adults with their physical and social environment is so important and identifying factors associated with satisfaction among the older adults living at home and nursing home are needed to assess on the basis of the ecological approach.
- Living with spouse at home and owning the house in which (s)he lives are significantly related factors to home satisfaction of older adults.
- Participating in social activities and having hobbies are important for residence satisfaction among older adults either living at home or a nursing home.
- Having a visitor (family member or another person rather than a relative) at a nursing home increases the residence satisfaction.

The older adult population have been increasing around the World (Kasper, Freedman, Spillman, & Wolff, 2015) as well as in Turkey (Durak, 2018). The number of older adults to population proportion was 13% while this ratio will increase to 21% in 2050 and 28% at the end of the 21st century (United Nations, 2017, p. 6). Similarly, Turkey Statistical Institute (TSI, 2008) reported that the total population of individuals age 65 and older was 7.1% and the older adult population (65 and over age) increased by 17% in the last five years (TSI, 2017). Also, while the ratio of older adult population to total population was 7.7% in 2013, it increased to 8.5% in 2017 (TSI, 2017). According to population projections, the rate of older adult population was estimated to be 10.2% in 2023, 12.9% in 2030, 16.3% in 2040, 22.6% in 2060 and 25.6% in 2080 (TSI, 2017).

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National Association of Social and Applied Gerontology

In countries with growing older adult populations, a large number of studies have been conducted. Concerning the number of older adult population, studies conducted with this sample is necessary to understand aging-related problems and to find possible solutions to these problems. On the basis of the ecological perspective, comprehensive assessment of older adults living in different places is recommended (Ellis, Whitehead, Robinson, O'Neill, & Langhorne, 2011). Also, it is highlighted that socio-cultural variables affect representations of old age (Moreno, Sánchez, Huerta, Albala, & Márquez, 2016). In this respect, physical and social environment and aging interaction have been examined in the literature (i.e. Sachs et. al., 2011). In a cross-cultural study conducted in six countries over ten thousands of participants, older adults were more likely to live at home and less likely to live in institutions (Ellis et al., 2011). A study about home was more preferred by older adults and institutions were less preferred places to live (Farber et al., 2011). In case older adults had suffering illnesses and received inpatient treatment, they showed eagerness to return home after illnesses treated. Therefore, it can be said that the place of residence is so important for older adults. It was also found to be related to social contact which means based on place of residence, social contact differed especially among older adults having hearing problems (Shin, Baik, Chung, Heo, & Ha, 2017).

In a study revealing the importance of the housing for the older adults, 56.3% of the 55-69 age group individuals responded the place of residence was as "very important" and 39.4% answered the question "important" (Tufan, 2003). Also, older adults generally prefer to live their homes rather than a nursing home where is seen as "last chance" (Kalaycığlu, Tol, Küçükkural, & Cengiz, 2003), irreversible and isolated places by them (Soygur, 2000). As mentioned by Tufan (2003), "Even if the physical and sensory abilities of the older adults are diminishing, their house helps them to perceive their own existence positively. Our house is the only environment in which decisions are taken by ourselves and we are not attracted" (p.135). Therefore, it can be said that the home is becoming the central aspect of satisfaction with life in old age (Tufan, 2003). On the other hand, older adults living at home and having health problems such as dementia need help more than their counterparts living at an institution and they receive caregiving mostly from family or unpaid caregivers (Kasper et al., 2015). Also, it was reported that almost 40% of older adults (living in the US) have experienced health problems and their participation in daily activities are quite limited (Johnson, & Appold, 2017). Therefore, institutional care is also needed for older adults especially for cases having health problems.

In respect to the ecological perspective, other studies have also been conducted as comparing older adults living in rural or urban areas. Community in rural areas includes more social cohesion, more contact and more interactive atmosphere than urban areas (Shin et al., 2017). On the other hand, urban environments are seen as more stimulating cognitively, socially and relational (Cassarino, O'Sullivan, Kenny, & Setti, 2016). In a national survey conducted over 4000 individuals, the difference between older adults living in rural and urban areas was going to diminish in terms of health status and functionality in China (Wu, Yue, & Mao, 2015). In this study, the quality of the local environment (access to water) was important among rural residents. In another study conducted with Irish older adults (N=3765), older adults living in urban areas demonstrated better performance on cognitive abilities and executive functions than others living in urban areas (Cassarino et al., 2016). Therefore, both rural and urban areas have some advantages for older adults.

Regarding the ecological view, the people who live with is also mentioned to be important for older adults. In several countries, living with more than one generations are becoming prevalent and called multi-general houses. The spreading of the multi-generational houses is related to the effect of living with others on the well-being of older adults A descriptive study was conducted based on frequencies between 2001-2015 in US (Johnson, & Appold, 2017). The results revealed that the most of them were living with alone or with a spouse (69%), others were living with a child/

son-daughter (13.5%), grandchild (4.6%), and/or father or mother (3.8%). In this study, household typologies were identified as one generation households (alone) two-generation households (two or more adults with their offsprings), three plus generation houses (one or more adults, their offsprings and grandchildren) and missing generation houses (one or more adult with grandchildren). Based on this typology, most of US residents (79.2%) were living in a one-generation house and 15% of them had caretaker and caregiver households. Also, based on the owner of their home, 50% of them were the owner of their house and 20% were living in a rental house. Besides, 45% of them were living long-termly at the same home. Another Study conducted over 143 countries revealed that 55% of older adults lived with children, 15% of them lived with a spouse, and 12% of them lived alone (United Nations, 2017). These studies questioned the importance of households on older adults despite revealing descriptive results. In a study examining people live with and quality of life and personal distress, older adults live alone had lower scores about the quality of life and higher scores of personal distress than the ones living with a spouse (Henning-Smith, 2016). On the contrary, this result was quite different based on the gender variable. Women older adults live with other people (i.e. spouse) had lower scores of quality of life and had higher scores of personal distress than men. The researcher explained the difference as the value of living with others to explain older adults live with someone. However, this relationship sometimes does not exist since social support might create distress among especially women older adults.

As the aforementioned studies mentioned above demonstrates, older adults interact with their physical and social environment is so important. To enhance age-friendly societies, understanding the physical and social environment on aging adults is important (Johnson, & Appold, 2017). The purpose of this research is to determine the characteristics of older adults living at home and nursing home and to compare their preferences on the basis of their satisfaction about living place. Therefore, the characteristics of older adults living at home and nursing home are aimed to examine on the basis of their satisfaction in the present study. In terms of their satisfaction with the living either home or nursing home, variables related to their environment (age, gender, social activities, people who live with, visits and visitors) are compared. In respect to hypotheses, there would be differences between variables related to the environmental variables.

Methods

Participants

The sample of the present study consists of 1770 older individuals. Based on the living place, 52 % of them were living in nursing homes (n = 924) and 48 % of them were at home (n = 846). To collect the data from those participants, simple random sampling by clustering technique was provided by the Turkish Statistical Institute (TurkStat). Participants were selected older adults who do not have any cognitive impairment. All participants were 60 or older and their age ranged between 60 and 100 (M = 73.82, SD = 7.97) (for detailed information, see Table-1)

Demographic Information Form

A socio-demographic information form including gender, education level, income, marital status, place of residence, participation in social activities, and a number of visitor in a nursing home was asked to participants. Additionally, the participants were asked to rate their residence (home and nursing home) satisfaction on a 10 point Likert scale (1=Not satisfied at all, 10= Completely satisfied).

Procedure

In order to conduct the study, ethical approvals were taken from both Human Research Ethics Committee (Abant Izzet Baysal University) and Ankara Clinical Research Ethics Committee (Ministry of Health, General Directorate of Pharmaceuticals and Pharmacy.) Also, in order to collect data from nursing homes, the permission was taken from the "Turkish Ministry of Family and Social Policy". Also, in order to reach the older adults residing at home,

Table-1. Socio-demographic characteristics of participants

	NURSING HOME (N = 924)		HOME (N = 846)		TOTAL (N = 1770)	
	M	*SD*	*M*	*SD*	*M*	*SD*
Age	76.42	7.37	70.99	7.63	73.82	7.97
Monthly Income*	979	2214	1744	1398	1352	1900
	F	*%*	*F*	*%*	*F*	*%*
Gender						
Women	403	43.61	440	52.01	843	47.63
Men	521	56.39	406	47.99	927	52.37
Marital Status						
Single / never married	92	9.96	22	2.60	114	6.44
Married	165	17.86	540	63.83	705	39.83
Divorced	196	21.21	34	4.02	230	12.99
Widow	471	50.97	250	29.55	721	40.73
Education Level						
Literate	216	23.38	149	17.61	365	20.62
Primary school graduate	312	33.77	279	32.98	591	33.39
Secondary school graduate	118	12.77	90	10.64	208	11.75
High school graduate	169	18.29	165	19.50	334	18.87
College graduate	44	4.76	65	7.68	109	6.16
Graduated from a university	65	7.04	98	11.59	163	9.21
*Place of Residence***						
Village	101	10.93	112	13.24	213	12.03
Town	32	3.46	105	12.41	137	7.74
City	133	14.39	135	15.96	268	15.14
Metropolitan (suburb)	66	7.14	81	9.57	147	8.31
Metropolitan (center)	592	64.07	413	48.82	1005	56.78
Number of Children						
No children***	223	24.13	72	8.51	295	16.67
One child	159	17.21	102	12.06	261	14.75
Two children	239	25.87	267	31.56	506	28.59
Three children	150	16.23	219	25.89	369	20.85
Four and more children	153	16.56	186	21.99	339	19.15
Working Status						
Still working	12	1.30	72	8.51	84	4.75
Currently not working	684	74.03	462	54.61	1146	64.75
Housewife	228	24.68	312	36.88	540	30.51
General Health Insurance						
No	106	11.47	41	4.85	147	8.31
Yes	818	88.53	805	95.15	1623	91.69

* = Turkish Lira (₺)
** = The longest duration of life
*** = Include single older adults

address information was taken from the "Turkish Statistical Institute (DIE)" which provided help to researchers about a random assignment for the individuals living at home. Participants were visited in their living environment (home or institution) and the purpose of the study was explained to them. After participants were informed about the study, they participated in the study voluntarily by means of face to face interaction and with the help of researchers while completing forms. It took 15-25 minutes to complete the questionnaires.

Results

Gender and Marital Status Difference on Place of Residence

In the present study, a chi-square test of independence was performed to examine the relationship between gender and residence type. As can be seen by the frequencies cross-tabulated in Table-2, there is a significant relationship between gender and residence type, $\chi 2$ (1, N = 1770) = 12.48, p = 4.12e-04, Cramer's V = .08. However, the effect size for this analysis is small according to the Cramer's V criteria (Télleza, Garcíaa, & Corral-Verdugo, 2015).

Table-2. Chi-square results for gender X residence type

	Women	Men	Total	$\chi^2(1)$	*Cramer's V*	*p*
Nursing Home	403 (440.07)	521 (483.93)	924			
Home	440 (402.93)	406 (443.07)	846	12.48	.08	4.12e-04
Total	843	927				

Note: Expected values shown in parentheses.

While more men (N = 521, 56.4%) than women (N = 403, 43.6%) were living at the nursing home, more women (N = 440, 52.01%) than men (N = 406, 47.99%) were living at home among the participants in the study.

Additionally, a chi-square test of independence was performed to examine the relation between marital status and residence type. According to the cross tabulation demonstrated in Table-3, there is a highly significant relationship between gender and residence type, $\chi 2$ (1, N = 1770) = 421.68, p = 4.46e-36, Cramer's V = .49. Widowed older adults (N = 471, 51.0%) were living more at a nursing home than married (N = 165, 17.9%), divorced (N = 196, 21.2%), and single older adults (N = 92, 10.0%). On the other hand, married older adults (N = 540, 63.8%) were living more at home than widowed (N = 250, 29.6%), divorced (N = 34, 4.0%), and single older adults (N = 22, 2.6%). The effect size for this analysis is large according to the Cramer's V criteria (Télleza, Garcíaa, & Corral-Verdugo, 2015) and those results supported the presence of higher frequency of single, divorced and widowed at the nursing home and higher frequency of the married at home.

Table-3. Chi-square results for marital status X residence type

	Nursing Home	Home	Total	$\chi^2(3)$	*Cramer's V*	*p*
Married	165_a (368.03)	540_b (336.97)	705			
Single	92_b (59.51)	22_a (54.49)	114			
Divorced	196_b (120.07)	34_a (109.93)	230	421.68	.49	4.46e-36
Widowed	471_b (376.39)	250_a (344.61)	721			
Total	924	846				

Note 1: Expected values are shown in parentheses.
Note 2: Each subscript letter denotes a subset of the place of residence categories whose column proportions do not differ significantly from each other at the .05 level.
Note 3: Subscript letter of b demonstrates a bigger proportion than the subscript letter of a.

Gender, Place of Residence, and Alternative Place of Residence Relationships

According to the cross tabulation demonstrated in Table-4, there is a significant relationship between place of residence (village, town, city- metropolitan) and alternative place of residence type, $\chi 2$ (7, N = 846) = 52.98, p = 3.73e-9, Cramer's V = .25. Older adults who were in the village, town, and city preferred more to live with their children

Table-4. Chi-square results for the place of residences X alternative residence preferences (Where would you prefer to stay if you didn't stay at home right now?)

(S)he wants to live	Village, Town, and City	Metropolitan	Total	$\chi^2(7)$	*Cramer's V*	*p*
with her/his children	97_b (66.2)	62_a (92.8)	159			
with relatives and friends	9_a (9.6)	14_a (13.4)	23			
in a natural or holiday settings	18_a (27.0)	47_b (38.0)	65			
in a nursing home	46_a (68.2)	118_b (95.8)	164			
in her/his own country	25_a (25.8)	37_a (36.2)	62	52.98	.25	3.73e-9
where (s)he still lives in (no change)	65_a (79.5)	126_b (111.5)	191			
in her/his own house	80_b (66.6)	80_a (93.4)	160			
in a rented house	12_a (9.2)	10_a (12.8)	22			
Total	352	494				

Note 1: Expected values are shown in parentheses.

Note 2: Each subscript letter denotes a subset of the place of residence categories whose column proportions do not differ significantly from each other at the .05 level.

Note 3: Subscript letter of b demonstrates a bigger proportion than the subscript letter of a.

than individuals who were living in the metropolitan. Those individuals were also more likely to live their own home rather than older adults lived in the metropolitan. Older adults who were in metropolitan preferred more to live in natural/ holiday setting than older adults in village, town, and city. Older adults who were in metropolitan preferred more to live in a nursing home than older adults in village, town, and city. Older adults who were in metropolitan preferred more to live in the same place and they were preferred less to change living place than older adults in the village, town, and city.

According to the cross tabulation demonstrated in Table-5, there is a significant relationship between gender and alternative place of residence type, $\chi2$ (7, N = 950) = 29.33, p = 1.26e-04, Cramer's V = .19. Women were more likely to live with their children than men. Men were more likely to live in a natural/holiday setting and nursing home than women.

Table-5. Chi-square results for gender X alternative residence preferences (Where would you prefer to stay if you didn't stay at home right now?)

(S)he wants to live	Women	Men	Total	$\chi^2(7)$	*Cramer's V*	*p*
with her/his children	102_b (82.7)	57_a (76.3)	159			
with relatives and friends	13_a (12.0)	10_a (11.0)	23			
in a natural or holiday settings	22_a (33.8)	43_b (31.2)	65			
in a nursing home	69_a (85.3)	95_b (78.7)	164			
in her/his own country	30_a (32.2)	32_a (29.8)	62	29.33	.19	1.26e-04
where (s)he still lives in (no change)	105_a (99.3)	86_a (91.7)	191			
in her/his own house	91_a (83.2)	69_a (76.8)	160			
in a rented house	8_a (11.4)	14_a (10.6)	22			
Total	444	406				

Note 1: Expected values are shown in parentheses.

Note 2: Each subscript letter denotes a subset of the place of residence categories whose column proportions do not differ significantly from each other at the .05 level.

Note 3: Subscript letter of b demonstrates a bigger proportion than the subscript letter of a.

Characteristics of the Older Adults Residing at Home

Among the older adults residing at home, the majority of the participants live with their spouse (N = 340, 40.19%) or with their spouse and children (N = 214, 25.30%). In terms of house ownership, the majority of the participants live in their own house (N = 497, 58.75%). In terms of alternative residence places, mostly the participants prefer not to change their living places (N = 191, 22.58%), to live in a nursing home (N = 164, 19.39%) and to live with their children (N = 159, 18.79%). Regarding the type of aid offered by the state, other aids (N = 343, 40.54%), travel aids (N=163, 19.27%) and health services aids (N = 132, 15.60%) were the most common type of help. The majority of the participants reported that they did not participate in social activities (N = 559, 66.08%) (for detailed information, see Table-6).

Table-6. Characteristics of the older adults residing at home

	F	%		F	%
People who live together			Who belongs to the house (s)he lives in?		
Spouse	340	40.19	Herself/himself	497	58.75
Spouse + children	214	25.30	Spouse	134	15.84
Alone	113	13.36	Child	93	10.99
Children	96	11.35	Another (rent)	83	9.81
Close to someone*	83	9.81	Close to someone*	39	4.61
Alternative residence preferences** : (S)he wants to live…			Receiving services offered by the State or the Municipality		
where (s)he still lives in (no change)	191	22.58	Travel aids***	163	19.27
in a nursing home	164	19.39	Health services****	132	15.60
in her/his own house	160	18.91	Caring services at home*****	90	10.64
with her/his children	159	18.79	Other aids******	343	40.54
in a natural or holiday settings	65	7.68	No information	196	23.17
in her/his own country	62	7.33	Services needs offered by the State or the Municipality		
with relatives and friends	23	2.72	Travel aids	84	9.93
in a rented house	22	2.60	Health services	154	18.20
Participation in social activities			Caring services at home	73	8.63
No	559	66.08	Other aids	431	50.95
Yes	287	33.92	No information	293	34.63

Note-1: * Close person is a brother, sister, parent, relative, friend, etc.
Note-2: ** The question: Where would you prefer to stay if you have not stayed at home?
Note-3: *** Travel aids = Free / discount travel card, etc.
Note-4: **** Health services = Injection, inserting serum, sugar level - blood pressure measurement, transfer to the hospital with an ambulance/a car, urinary catheterization, wound care dressings
Note-5: ***** Caring services at home = Hair beard care, body cleaning, bathing, urinary catheterization, wound care dressings
Note-6: ****** Other aids = Financial support (in-kind / cash assistance), residential heating aid, cleaning assistance, paint assistance, diaper aid, and bill payment assistance

Characteristics of the Older Adults Residing at Nursing Home

Regarding who refers her/him to a nursing home, the majority of participants said herself/himself (N=680, 73.59%), her/his children (N=77, 8.33%), her/his relatives (N=66, 7.14%). In respect to the frequency of visiting the family outside to nursing home, the majority of them did not visit their family (N=423, 45.78%) and others visited a few times in a year (N=253, 27.38%). Regarding who visited her/him at the nursing home, the majority of them were visited by family members (N=569, 61.58%), relatives (N=408, 44.16%) and other contacts (N=396, 42.86). Regarding participating social activities, 47.08% (N=435) of them participated in social activities in a nursing home while 43.51% (N=402) did not participate in social activities. While the majority of them did not have any hobby (N=578, 62.55%), others had a hobby (N=346, 37.45%) (for detailed information, see Table-7).

Table-7. Characteristics of the older adults residing at the nursing home

	F	%		*F*	%
Referral to nursing home			Participating social activities in…		
Herself/himself	680	73.59	Not participating	402	43.51
Her/his children	77	8.33	Nursing home	435	47.08
Her/his relatives	66	7.14	Nursing home and outside	87	9.42
Her/his neighbors or others	57	6.17	People who visited her/him at the nursing home*		
Her/his Spouse	26	2.81	Family members	569	61,58
Her/his friends	18	1.95	Relatives	408	44.16
The frequency of visiting the family**			Other contacts	396	42.86
A few times in a year	253	27.38	No visitors	137	14.83
A few times in a month	149	16.13	Having a hobby		
At least once a week	99	10.71	No	578	62.55
Not going to visit her/his family	423	45.78	Yes	346	37.45

Note-1: * One resident might have more than one visitors, therefore total frequency is not 100% Note-2. ** Visiting the family outside the nursing home, at home

Place of Residence Satisfaction: Variables Associated with Home and Nursing Home Satisfaction

The participants were asked to rate their residence satisfaction on the scale of 1 to 10 by replying one question of "How satisfied are you with living at your home / nursing home?". The residents of home respond to the question with the mean of 8.65 (*SD* = 1.94) and those of nursing home with the mean of 8.19 (*SD* = 2.30) (see Table-8). To see variables associated with home satisfaction, gender, having a hobby, the participation of social activities variables were analyzed with t tests. An independent-samples t-test was conducted to compare home satisfaction scores of women and men. The test indicated that there was no significant difference in the home satisfaction scores for women and men, $t(844) = -.21$, $p = .831$, $d = .01$ (see Table-9).

An independent-samples t-test was conducted to compare home satisfaction scores of older adults having at least a hobby and those not having any hobby. The test indicated that scores were significantly higher for older adults having at least a hobby (*M* = 9.01, *SD* = 1.65) than for those not

Table 8. How satisfied are you in terms of living at/in…?

	YOUR HOME					NURSING HOME			
	F	%	*cF*	*c%*		*F*	%	*cF*	*c%*
1/10	12	1.42	12	1.42	1/10	21	2.27	21	2.27
2/10	2	0.24	14	1.65	2/10	12	1.30	33	3.57
3/10	8	0.95	22	2.60	3/10	27	2.92	60	6.49
4/10	10	1.18	32	3.78	4/10	15	1.62	75	8.12
5/10	41	4.85	73	8.63	5/10	57	6.17	132	14.29
6/10	41	4.85	114	13.48	6/10	55	5.95	187	20.24
7/10	71	8.39	185	21.87	7/10	72	7.79	259	28.03
8/10	120	14.18	305	36.05	8/10	120	12.99	379	41.02
9/10	82	9.69	387	45.74	9/10	150	16.23	529	57.25
10/10	459	54.26	846	100.00	10/10	395	42.75	924	100.00
M	*SD*	Minimum	Maximum		*M*	*SD*	Minimum	Maximum	
8.65	1.94	1	10		8.19	2.30	1	10	

Note-1: F = Frequency, cF = Cumulative frequency, c% = Cumulative percentage, M = Mean, SD = Standard deviation.

having any hobby (M = 8.30, SD = 2.13), t(844) = -5.42, p = 7.81e-08, d = .37 (see Table-9). These results suggested that at least having a hobby had an effect on home satisfaction for older adults. Specifically, when older adults engaged a hobby, they evaluated their home environment as more desirable.

An independent-samples t-test was conducted to compare home satisfaction scores of older adults participating in social activities and those not participating in social activities. The test indicated that scores were significantly higher for older adults participating in social activities (M = 8.99, SD = 1.54) than for those not participating in social activities (M = 8.47, SD = 2.10), t(844) = -3.70, p = 2.34e-04, d = .28 (see Table-9). These results suggested that participation in social activities had an effect on home satisfaction for older adults. In particular, when older adults participated in social activities, they saw their home as more pleasant. Several A one-way analysis of variance (One-way ANOVA) tests were calculated on home satisfaction scores. One-way ANOVA showed there was no main effect of age on home satisfaction, F(2, 843) = .62, p = .538.

One-way ANOVA showed a main effect of "people who live with" on home satisfaction, F(4, 841) = 4.61, p = 9.84e-04, η^2 = .02 (Table-10). Post-hoc analyses using Tukey's HSD indicated that home satisfaction scores were lower for older adults living alone than for older adults living with her/his spouse (p = .006). Additionally, home satisfaction scores were lower for older adults living with others (p = .046) and living with spouse and children (p = .019) than for older adults living with her/his spouse. Post-hoc analyses also indicated that home satisfaction did not differ significantly between older adults living alone and living with others (p = .999), living with children (p = .663), and living with spouse and children (p = .904). Additionally, Post-hoc analyses using Tukey's HSD indicated that home satisfaction did not differ significantly between older adults living with spouse and living with children (p = .511), older adults living with others and living with a spouse and children (p = .982).

Table-9. Independent-samples t-test results on home satisfaction for older adults residing at home

	N	M	SD	t	df	p	d
GENDER							
Women	440	8.63	1.93	-.213	844	.831	.01
Men	406	8.66	1.96				
HAVING a HOBBY							
No	430	8.30	2.13	-5.419	844	7.81e-08	.37
Yes	416	9.01	1.65				
PARTICIPATION in SOCIAL ACTIVITIES							
No	559	8.47	2.10	-3.695	844	2.34e-04	.28
Yes	287	8.99	1.54				

One-way ANOVA showed a main effect of "who belongs to house" on home satisfaction, F(4, 841) = 20.26, p = 6.04e16, η^2 = .09. Post-hoc analyses using Tukey's HSD indicated that home satisfaction scores were lower for older adults living at a home belongs to close person than for older adults living at a home belongs to her/himself (p = .001), for older adults living at a home belongs to spouse (p = .001), and for older adults living at a home belongs to children (p = .039). Also home satisfaction did not differ significantly between older adults living at a home belongs to close person and older adults living at a rented home (p = .781). Post-hoc analyses using Tukey's HSD indicated that home satisfaction scores were lower for older adults living at a rented home than for older adults living at a home belongs to her/

himself (p = .001), for older adults living at a home belongs to spouse (p = .001). Also, home satisfaction did not differ significantly between older adults living at a rented home and older adults living at a home belongs to children (p = .225). An independent-samples t-test was conducted to compare the nursing home satisfaction scores of older adults referred to a nursing home by herself/himself and those by others (i.e., spouse, children, relatives, friends, neighbors). The test indicated that satisfaction scores were significantly higher for older adults referred by herself/himself (M = 8.44, SD = 2.18) than for those referred by others (M = 7.49, SD = 2.47), t(922) = 5.60, p = 2.87e-08, d = .41 (see Table-11). These results suggested that referral to nursing home had an effect on the nursing home satisfaction for older adults. In particular, when the older adults settled in the nursing home by their own will they felt more delighted in a nursing home than referred by others.

An independent-samples t-test was conducted to compare nursing home satisfaction scores of older adults having visitors in nursing home and those not having visitors. The test indicated that scores were significantly higher for older adults having visitors in a nursing home (M = 8.27, SD = 2.21) than for those not having visitors (M = 7.73, SD = 2.73), t(922) = -2.53, p = .012, d = .22 (see Table-11). These results suggested that the presence of visitors had an effect on a nursing home satisfaction for older adults. In particular, older adults with guests were more satisfied with the nursing home than older adults without guests.

Table-10. One-way ANOVA results: Group differences on home satisfaction

	N	M	F	df	p	Partial η^2
			AGE			
Adult-young-old (60-74)	230	8.53				
Middle-old (75-84)	578	8.69	.621	2, 843	.538	.01
Old-old (85+)	38	8.71				
			PEOPLE WHO LIVE with			
With spouse	340	8.98_{c}				
With children	96	8.63_{abc}				
With spouse and children	214	8.46_{ab}	4.671	4, 841	9.84e-04	.02
With Others	83	8.33_{ab}				
Alone	113	8.27_{a}				
			WHO BELONGS to HOUSE			
Herself/himself	497	8.98_{c}				
Spouse	134	8.90_{c}				
Children	93	8.13_{b}	20.257	4, 841	6.04e16	.09
Another (rent)	83	7.54_{ab}				
Close to someone	39	7.13_{a}				

Note-1: Means with different subscripts are significantly different from each other.

An independent-samples t-test was conducted to compare the nursing home satisfaction scores of older adults having family member visitors at the nursing home and those not having family member visitors. The test indicated that satisfaction scores were significantly higher for older adults having family member visitors at the nursing home (M = 8.32, SD = 1.19) than for those not having family member visitors (M = 7.97, SD = 2.45), t(922) = -2.25, p = .024, d = .15 (see Table-11). These results suggested that the presence of family member visitors had an effect on the nursing

home satisfaction for older adults. Specifically, when older adults had family member visitors the nursing home they evaluated their environment as more desirable.

An independent-samples t-test was conducted to compare the nursing home satisfaction scores of older adults having relative visitors in a nursing home and those not having relative visitors. The test indicated that there was no significant difference in the nursing home satisfaction scores for older adults having relatives visitors at the nursing home and those not having relatives visitors, $t(922) = -1.58$, $p = .116$ (see Table-11).

An independent-samples t-test was conducted to compare the nursing home satisfaction scores of older adults having other visitors at the nursing home and those not having other visitors. The test indicated that satisfaction scores were significantly higher for older adults having other visitors at the nursing home ($M = 8.37$, $SD = 2.11$) than for those not having other visitors ($M = 8.05$, $SD = 2.42$), $t(922) = -2.05$, $p = .040$, $d = .14$ (see Table-11). These results suggested that the presence of other visitors had an effect on the nursing home satisfaction for older adults. Specifically, when older adults had other visitors (who are non-relatives) at the nursing home they evaluated their nursing home environment as more satisfied.

An independent-samples t-test was conducted to compare the nursing home satisfaction scores of older adults having at least a hobby in and those not having any hobby. The test indicated that scores were significantly higher for older adults having at least a hobby ($M = 8.53$, $SD = 1.94$) than for those not having any hobby ($M = 7.98$, $SD = 2.47$), $t(922) = -3.55$, $p = 4.10e-04$, $d = .25$ (see Table-11). These results suggested that having at least a hobby had an effect on a nursing home satisfaction for older adults. Specifically, older adults having at least a hobby had evaluated nursing home as more satisfied.One-way ANOVA showed there was no main effect of age on the nursing home satisfaction, $F(2, 921) = 1.42$, $p = .243$.

One-way ANOVA showed a main effect of "visit-

Table-11. Independent-samples t-test results on the nursing home satisfaction for older adults residing in a nursing home

	N	M	SD	t	df	p	d
			GENDER				
Women	403	8.48	2.07	3.441	922	6.06e-04	.23
Men	521	7.96	2.44				
			REFERRAL to NURSING HOME				
Herself/himself	680	8.44	2.18				
Other	244	7.49	2.47	5.598	922	2.87e-08	.41
			PRESENCE of VISITORS				
No	137	7.73	2.73	-2.530	922	.012	.22
Yes	787	8.27	2.21				
			HAVING FAMILY VISITORS				
No	355	7.97	2.45	-2.254	922	.024	.15
Yes	569	8.32	2.19				
			HAVING RELATIVE VISITORS				
No	516	8.08	2.42	-1.575	922	.116	.10
Yes	408	8.32	2.13				
			HAVING OTHER VISITORS				
No	528	8.05	2.42	-2.052	922	.040	.14
Yes	396	8.37	2.11				
			HAVING a HOBBY				
No	578	7.98	2.47	-3.547	922	4.10e-04	.25
Yes	346	8.53	1.94				

ing sequence of the family" on the nursing home satisfaction, $F(3, 920) = 9.69$, $p = 3.00e\text{-}06$, $\eta^2 = .03$ (Table-12). Post-hoc analyses using Tukey's HSD indicated that the nursing home satisfaction scores were lower for older adults not going to visit her/his family than for older adults visiting her/his family few times in a year ($p = .001$), few times in month ($p = .001$), and at least once a week ($p = .001$), but the nursing home satisfaction did not differ significantly between older adults visiting her/his family few times in a year and few times in month ($p = .816$), older adults visiting her/his family few times in a year and at least once a week ($p = .792$), older adults visiting her/his family few times in month and at least once a week ($p = .999$).

Table-12. One-way ANOVA results: Group differences on the nursing home satisfaction

	N	M	F	df	p	Partial η^2
			AGE			
Adult-young-old (60-74)	377	8.03				
Middle-old (75-84)	407	8.29	1.415	2, 921	.243	.01
Old-old (85+)	140	8.31				
			VISITING SEQUENCE of FAMILY			
A few times in a year	253	8.44_b				
A few times in a month	149	8.64_b	9.692	3, 920	3.00e-06	.03
At least once a week	99	8.69_b				
Not going to visit	423	7.76_a				

Note-1: Means with different subscripts are significantly different from each other.

Discussion

When considering the higher number of older adults around the World (United Nations, 2017), promoting age friendly societies is quite important (Johnson, & Appold, 2017). In this study, basic characteristics of older adults living either at home or nursing home were investigated on the basis of ecological perspective. Also, variables associated with satisfaction about where they lived were examined.

Place of residence/Gender and Alternative Place of Residence Relationships

To see gender by place of residence relationship, a chi-square results revealed that the data were gathered from more men than women at the nursing home and from more women than men at home in the present study. Considering the random assignment provided by TurkStat, it can be assumed that these distribution reflected gender balance at the nursing homes. When men stay alone in Turkish society, they are more likely to live at the nursing home. On the other hand, women's preferencet is to stay at their homes rather than going to a nursing home. Same results were found by United Nations (2017) that women were more likely to live atthe home.

Additionally, a chi-square test of independence was performed to examine the relation between marital status and residence type. Results revealed that widowed older adults were living at the nursing home more than married, divorced, and single older adults. On the other hand, married older adults were living at home more than widowed, divorced, and single older adults. This result supports the idea of higher frequency of single, divorced and widowed at the nursing home and higher frequency of the married at home. Those results supported familial contact is associated with nursing home practices (Moreno et al., 2016). Also, place of residence (village, town, city vs. metropolitan) and alternative place of residence relationship were investigated in the

present study. Older adults who were in the village, town and city preferred more to live either with their children or their own home rather than older adults lived in metropolitan. In a traditional life, it is expected to stay with children and live in their own home. When looking at older adults who were in metropolitan, they preferred more to live in natural/ holiday setting, if this is not possible, to live in where they were actually living (no change wish) or to live at the nursing home than older adults in village, town and city. In conclusion, considering those results, older adults living in metropolitan preferred to live in relaxing environment (i.e., nature or sea). If this is not possible, they preferred to stay at the same place or accept to consider live at the nursing home options. As mentioned in some studies, societal changes have influence on older adults that older adults consider nursing home practice due to decreased number of family carers (Moreno et al., 2016). On the other hand, individuals at village, town, and city preferred to live their own home that is close to their children. Again, since close society ties appear in those places, there are still opportunity to obtain family careers when needed.

In addition to place of residence and alternative place of residence relationship, gender and alternative place of residence relationship was investigated. While women were more likely to live with their children than men, men were more likely to live in natural/holiday setting than women. Also, men were accepting more to live at the nursing home than women. Considering those results, women wish to share more with children while men wish to stay calm and relax.

Older Adults Living at Home and at the Nursing Home

Regarding the characteristics of older adults living at home, the majority of the participants live with their spouse or with their spouse and children similar to other studies (Johnson, & Appold, 2017; United Nations, 2017). The majority of the participants was living at their own house likewise in US (Johnson, & Appold, 2017). In respect to alternative residence place, mostly, they preferred to not to change living place as appear in US study (Johnson, & Appold, 2017). Others wanted to live at the nursing home and wanted to live with children. Regarding the type of aid offered by state, most of them took other aids including mostly financial support (in-kind / cash assistance) and other benefits similar to financial assistance (i.e., residential heating aid, cleaning assistance, paint assistance, diaper aid, and bill payment assistance). They reported also to receive travel aids and health services aids. In respect to social activities, the majority of the participants reported that they did not participate in social activities likewise seen in other studies (Johnson, & Appold, 2017).

Regarding the characteristics of older adults living at the nursing home, majority of participants referred to a nursing home by herself/himself, while others were referred by her/his children, and her/his relatives. As mentioned in the literature, individuals were preferred to live at the nursing home due to lack of family network when needed (Moreno et al., 2016). In respect to frequency of visits of the family outside to nursing home, the majority of them did not visit their family and others visited a few times in a year. Regarding who visited her/him at the nursing home, majority of them were visited by family members, relatives and other contacts. Besides, regarding participating social activities, the most of them participated social activities in nursing home while there were significant people not participating any social activities. Also, the majority of them did not have any hobby.

Variables Associated with Home and Nursing Home Satisfaction

In this study, the participants were rated their residence satisfaction on the 10 point Likert scale. Both older adults living at home at home (X=8.65; *SD* = 1.94) and nursing home (8.19; *SD* = 2.30) reported higher satisfaction when considering mean scores of satisfaction.

To see variables associated with home satisfaction, gender, having a hobby, participation of social activities variables were analyzed. To begin with gender, home satisfaction scores of women and men did not significantly different from each other. Both of them reported similar satisfac-

tion scores. When comparing home satisfaction scores of older adults having at least a hobby, they had higher scores of satisfaction than those not having any hobby. These results suggest that having at least a hobby is essential for home satisfaction among older adults. When older adults engage a hobby, they evaluate their home environment as more desirable. Besides, older adults participating in social activities had higher home satisfaction scores than for those not participating in social activities. Encouraging to participate activities for older adults living at home are recommended. Additionally, in terms of "people who live with", home satisfaction scores were lower for older adults living alone than for older adults living with her/his spouse. As mentioned in the literature, spouses receives support from each other (Okabayashi et al., 2004). Likewise, adults live alone had lower scores about the quality of life and higher scores of personal distress than the ones live with a spouse (Henning-Smith, 2016). Also, home satisfaction scores were lower for older adults living with others, living with both spouse and children than for older adults living with her/his spouse. Based on United Nations (2017) survey conducted over 143 countries, "who is the head of household" is important question for older adults living with children and spouse. When older adults co-reside with their children, their satisfaction was low. Therefore, understanding other parameters might be important for the variable "who live with". On the other hand, it can be said that living with spouse was related with higher satisfaction as seen in other studies (Henning-Smith, 2016). Moreover, regarding "who belongs to house" variable, older adults living at a home belongs to close person had lower satisfaction scores than those living at a home belongs to her/himself or spouse. Likewise US residents (Johnson, & Appold, 2017), Turkish older adults preferred to be owner of their homes. People live in a rental house also had lower scores of satisfaction than older adults living at a home belongs to her/himself or to a spouse. Those results might be related to anticipatory anxiety about possibility to change their living places in case their control is low.

To see variables associated with nursing home satisfaction, several independent sample t tests were performed. In respect to decision about living at a nursing home, older adults referred by herself/himself had higher scores of satisfaction than for those referred by others. These results, particularly, recommend that once the older adults settle within the institution by their own will, they feel additional delighted during an institution than referred by others. These results suggest that professionals might work with people referred to nursing home by others. Regarding having visitors variable, older adults having visitors obtained higher scores of satisfaction than for those not having visitors. Moreover, regarding family member visitors, older adults having family member visitors had higher scores of satisfaction than for those not having family member visitors. When the family members visited the older adults at the nursing home, the older adults perceives the nursing home as a pleasant place. Similar with family visitors, when older adults had others visitors (who are non-relatives) at the nursing home they evaluated their nursing home environment as more satisfied. These results suggest that older adults having visitors and especially family member visitors and other visitors evaluate nursing home environment in a more desirable way. Similar results were obtained in another study that older adults not having visitors had higher depression scores than counterparts (Hacıhasanoğlu & Yıldırım, 2009). Regarding "visiting sequence of family" on nursing home satisfaction, people visiting her/his family few times in a year, in a month, and at least once a week had higher scores of satisfaction than people did not have any visits. Therefore, professionals can encourage family visits since continuing social ties are important for older adults (Moreno et al., 2016). Regarding hobby status, older adults having at least a hobby had higher satisfaction scores than counterparts. Therefore, professionals can support hobbies at the institutions.

The present study has a limitation about not making causality since the design is cross-sectional. Also, results cannot be generalized older adults living in another country since all participants were Turkish older adults. Further studies comparing older adults living at home or nursing home would help researchers to explore variables associated with well-being (Durak, 2018). Satisfaction with life, flourishing and affective well-being measures

can be used to evaluate subjective well-being in future studies.

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Community Centers of Local Governments for Retirees: The Case of Istanbul

Abstract

The population of Turkey is aging. When local governments increase the quantity and quality of services for older people, the social welfare of older people increases as well. Among the special services for older people in the local administrations, community centers come first. This study examines the quality and diversity of services in community centers. In addition, the contribution of these centers to the activeness of older people living in the city is examined. In 2018, a cross-sectional survey was conducted in January and February, and a questionnaire was applied to 269 participants aged 55 years and older in the districts of Istanbul; Kadıköy, Maltepe, Üsküdar, Tuzla, Beşiktaş and Şişli. Research data were analyzed with the help of the SPSS 21 (2012) program. According to the results of the analysis, 42.7% of the participants were single individuals and15.1% of the participants were living alone at home. While 63.9% of the participants stated that they do sports, 70.3% of those who do sports said that this activity was "walking". The most of the participants (44.2%) stated that they participated in the social activities of these centers. As the reason for the participants' using the community center, 68% of the participants chose the option of meeting with their friends, 52% chose to have new friendships, 48.3% of them chose the option of eliminating their loneliness. The 65-74 age group who use the community center are doing more regular sports than the ones aged 75 and over χ^2 = 6.851, *p* 3.30e-02. Women who use the community center do more regular sports than men χ^2 = 11.423; *p* 1.00e-03. It could be said that the community centers are important alternative public spaces in the city, especially for older people living alone.

Keywords: Active aging, community center, urbanization, social policy, local administrations

Key Practitioners Message

- Community centers of local governments could contribute to the activity of older people.
- It is important to make regular sports for the older person.
- Regular physical activity may vary according to gender.

Introduction

The population is getting older depending on the developments in technology and health (Turner & Tatlıcan, 2011). It is estimated that the number of individuals over 60 years of age will reach 2 billion by 2050 (UN DESA, 2015). As is the general trend in the world, the proportion of older people in the population is increasing in Turkey. It is assumed that the ratio of the population over 65 years of age, which is 8.5% in 2018, will exceed 12% in 2030 and 20% in 2050 (UN DESA, 2015). It is estimated that life expectancy, which was 54

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years for women and 51 years for men in the 1960s, will increase to 74 years for women and 79 for men in 2030 (EYH, 2013, p. 9). According to TURKSTAT (2016), the number of seniors 65 and over in Turkey is 6.651.503. It is thought that the proportion of older people in Turkey will reach a critical amount both economically and socially, as in developed countries, in the short period of thirty years.

The senior population in Turkey is estimated to be living mainly in cities and will especially live in big cities in the future (Kurtkapan, 2018). Active living in a safe environment is important for older people (Şentürk & Altan, 2015). It could be said that local government services contribute to the activeness of older people living in cities. The community centers that the local administrations have allocated for the use of seniors are considered to accomplish this.

In the literature, there is an activity theory that explains both the individual and social importance of productivity during old age. According to this theory, seniors tend to continue their activity as long as their physical conditions allow it (Achenbaum & Weiland, 1996; Cockerham, 1991). This is necessary to overcome many problems in old age (Powell, 2006; Victor, 2005).

The concept of active old age that emerged since the early 1990s examines sports, participation in labor force, and social, economic and cultural events (Kalınkara, 2013). The World Health Organization focuses on old age and emphasizes the active old age concept, which includes the message of healthy aging and more social participation. It is stated that active old age increases the quality of life of seniors and maximizes opportunities for social security (Baran & Bahar-Özvarış, 2012; Görgün-Baran & Kurnaz, 2013; Yalçın, 2013). Active aging, which includes living in the highest quality and an increased lifespan, consists of the individual being active and maintaining their relationships and roles in society (Aydıner Boylu, 2013).

What can be done for older people in Turkey is an important part of social policy. Creating an environment where seniors could live actively is becoming a top priority. This is demonstrated in that local administrations allocate places specifically for seniors, and social and cultural activities in these places make some of the older people more social. Social connections, such as frequent participation in social activities, is good for cognitive ability in older people (Zunzunegui et al, 2003). Also, these activities help to reduce social isolation (Toepoel, 2012).

Methods

This study investigated the activities of the districts' local administrations in Istanbul in terms of community centers they have opened for older people. The research was conducted in the Kadıköy, Üsküdar, Beşiktaş, Maltepe, Şişli and Tuzla districts.

Participants

The study was carried out with 269 participants, using a cross-sectional design. The questionnaire form contains personal and demographic information. Data collection was done following face to face interview models. Interviewees consisted of men and women aged 55 and over.

Procedure

The research was carried out in two stages. In the first stage, the questionnaire was developed as a result of the literature survey, and the questionnaire was finalized after the pilot interviews and expert opinion. Participants were contacted from January to February of 2018 at the community centers of local administrations in Istanbul. The ethics committee approval which was received from Nevşehir Hacı Bektaş Veli University for conducting the research is available with the ethics committee report number is 04.01.2018/01, and research permits were obtained from the relevant local governments. During the interviews, the participants were also informed, and their approval was obtained. The aim of the study was to examine the activities of the local administrations' community centers. Descriptive statistical analysis was used to evaluate the data. The IBM SPSS 21 (2012) program was used for statistical analysis.

Results

This section includes analysis of data obtained from the questionnaire taken by individuals over 55 years of age. Firstly, the demographic characteristics of the participants were examined. Secondly, whether the participants do sports was evaluated. Thirdly, the reasons for the participants using the community center and the activities they participated in there were evaluated. Finally, findings determine whether the participants' regular sports are dependent on gender and age variables or not by using a chi-square test.

As can be seen in Table-1, the majority of the participants are female (N = 134, 49.4%). The majority of the participants are 65-74 years old (N = 116, 43.1%). 55-64 years old (N = 90, 33.5%), and (N = 63, 23.4%) are aged 75 years and over. Most of the participants (N = 115, 42.7%) were single individuals. The rate of older people living alone at home is (N = 41, 15.1%).

Table-1. Personal characteristics of participants

Variables	f	(%)
Gender		
Female	134	49.8%
Male	139	50.2%
Age		
55-64	90	33.5%
65-74	116	43.1%
75+	63	23.4%
Marital Status		
Married	153	56.9%
Single	115	42.7%
No answer	1	0.4%
Number of Residents		
Alone	41	15.2%
2 Individuals	99	36.8%
3-4 Individuals	95	35.3%
5 and over	23	8.6%
No answer	11	4.1%
Total	269	

Note-1. f = Frequency

Community centers are places that local governments open for older people. Older people chat there and organize events. They engage in various social and cultural activities. The older people establish new friendships, eliminate loneliness, and socialize by participating in activities. These centers have a positive impact on the active participation of older people. Therefore, these centers should be expanded at the neighborhood level. In these centers, various activities, especially sports, should be increased.

As could be seen in Table-2, 63.9% of the research participants do regular sports, 70.3% of them do regularly walking, and 18.1% of them do regularly swim or used fitness equipment.

Table-2. Participants' regular sports status

Do you do sports?	f
Yes	172
No	83
No answer	14
Total	269
What kind of sports do you do?	**f**
Walking	121
Swimming	25
Fitness equipment	6
Other	20
Total	172

Note-1. f = Frequency

As could be seen in Table-3, participants' reasons for using the community center are as follows: 183 (68%) chose to meet with friends; 142 (52.8%) chose to participate in activities; 140 (52%) chose to make new friends; 130 (48.3%) chose to eliminate loneliness; 121 (45%) chose to talk about current issues; and 94 (34.9%) chose to share their problems with others.

Table-3. Frequency and percentage values for the question of the reason for using the community center (N = 269)

	Eliminating loneliness		Meeting with friends		Talking about current issues		Sharing problems		Making new friends		Partici-pating in activities		Play games (card games)		Sports	
	f	%	f	%	f	%	f	%	f	%	f	%	f	%	f	%
Yes	130	48.3	183	68.0	121	45	94	34.9	140	52	142	52.8	39	14.5	39	14.5
No	139	51.7	86	32.0	148	55	175	65.1	129	48	127	47.8	210	78.1	184	68.4
No answer	-	-	-	-	-	-	-	-	-	-	-	-	20	7.4	46	17.1

Note-1. f = Frequency

As can be seen in Table-4, the most selected option for the question of the activities participants participate in is the social activities option. This is demonstrated in that 119 (44.2%) of the participants stated that they participate in social activities, while 89 (33.1%) of them participate in training activities, 76 (28.3%) of them participate in health activities, 69 (25.7%) of them participate in cultural activities, and 63 (23.4%) of them participate in chat activities in these centers.

Table-4. Frequency and percentage values for the question of activities older people participate in the community center (N = 269)

	Health activities		Training activities		Cultural activities		Social activ-ities		Chat activ-ities		Volunteering activities		Donation activities		Other activ-ities	
	f	%	f	%	f	%	f	%	f	%	f	%	f	%	f	%
Yes	76	28.3	89	33.1	69	25.7	119	44.2	63	23.4	41	15.2	35	13	23	8.6
No	193	71.7	180	66.9	200	74.3	150	55.8	206	76.6	228	84.8	234	87	246	91.4

Note-1. f = Frequency

A chi-square test of independence was performed to examine the relationship between gender and regular sports. As can be seen, by the frequencies cross-tabulated in Table-5, there is a highly significant relationship between gender and doing regular sports χ^2 = 11.423; p = 1.00e-03. Women who use the community center do sport more regularly than men.

Table-5. Chi-square test results to determine whether or not regular sports are dependent on gender variables

		Gender: Female	Male	Total	χ^2	df	P
Regular Sport	Yes	101 (88.36)	71 (83.64)	172	11.423	1	1.00e-03
	No	30 (42.64)	53 (40.36)	83			
	Total	131	124				

Note-1. Expected values are shown in parentheses.

As can be seen in the Table-6, the correlation between the variables was found to be statistically significant χ^2 = 6.851, p = 3.30e-02. The 65-74 age group who use the community center are doing more regular sports than the ones aged 75 and over.

Discussion

Cities have many advantages for older people, but they also have some problems. Seniors living in the city are increasingly isolated from social life and in turn their activity decreases (Moody & Sasser, 2012; Victor, 2005; Weeks, 1984). Increasing

Table-6. Chi-square test results to determine whether or not regular sports are dependent on age variables

		Age Group			Total	χ^2	df	p
		55-64	65-74	75+				
Regular Sport	Yes	59 (59.4)	80 (72.2)	33 (40.5)	172	6.851	2	3.30e-02
	No	29 (28.6)	27 (34.8)	27 (19.5)	83			
	Total	88	107	60	255			

Note-1. Expected values are shown in parentheses.

isolation in big cities affects most older people of all age groups (Görgün-Baran, 2012). Loneliness in urban life where isolation is increasing constitutes an important issue to be addressed for seniors. The existence of seniors who do not leave their homes due to various reasons in today's cities is a fact of life. Local governments are responsible for reducing anxiety in some of these seniors and opening reliable places in areas where they will go.

It could be said that some of the community centers in the five districts of the study have an important place in the activity of seniors living in the city. It cannot be said that the community centers respond to all the needs of the seniors, but these centers are an important alternative public space as much as the park and tea gardens in the city, especially for seniors living alone. Seniors come to these centers and chat at certain times of the day. It is stated that seniors who do not often leave the house in their old age can get out of the house at certain times of the week through artistic activities in the community centers. New friendships are established and some of these friendships have even reached a point where two friends' grandchildren have gotten married (Kurtkapan, 2018). These centers are able to offer opportunities for older people to communicate with their peers.

As a result of resources, the correlation between the variables was found to be statistically significant χ^2 = 6.851, p = 3.30e-02. The 65-74 age group who use the community center are doing more regular sports than the ones aged 75 and over. The correlation between these variables was found statistically significant χ^2 = 11.423; p = 1.00e-03. For example, women who use the community center do so more regularly than men.

The most selected option to the question of the activities participants participate in in the community center is the social activities option. Of the participants, 119 (44.2%) stated that they participate in the social activities, 89 (33.1%) of them participate in the training activities, 76 (28.3%) of them participate in the health activities, 69 (25.7%) of them participate in cultural activities, and 63 (23.4%) of them participate in chat activities in these centers.

Participants' aims of using the community center are as follows: 183 (68%) chose to meet with friends; 142 (52.8%) chose to participate in activities; 140 (52%) chose to make new friends; 130 (48.3%) chose to eliminate loneliness; 121 (45%) chose to talk about current issues; and 94 (34.9%) chose to share problems.

The senior center supports successful aging by maintaining older peoples' mental and physical health (Dal Santo, 2009). The community centers' activities improve physical function in older adults (Fitzpatrick, et al., 2008). Based on the current research findings, it is suggested that future research should focus on highlighting the need of older people living in the city and on the role of community centers in fulfilling the need of this group of people of the community.

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Vision and Mission

The major goal of the ***Journal of Aging and Long-Term Care (JALTC)*** is to advance the scholarly contributions that address the theoretical, clinical and practical issues related to aging and long-term care. The ***JALTC***, while making efforts to create care services for older people at the best quality available that are more humane, that pay special attention to people's dignity, aims from the perspective of the whole aging process- to discuss Social Care Insurance as a human right, to contribute care for older people to be transformed into an interdisciplinary field, to integrate care services for older people and gerontological concepts and to create more effective collaboration between them, to enhance the quality of care services for older people and the quality of life of caregivers from medical, psychological and sociological perspectives, to highlight the cultural factors in care for older people, to increase the potential of formal and informal care services, to provide wide and reachable gerontological education and training opportunities for caregivers, families and the older people.

Aims and Scope

"National Association of Social and Applied Gerontology (NASAG)"has recently assumed responsibility for the planning and introduction of a new international journal, namely, the **Journal of Aging and Long-Term Care (JALTC)**. With world societies facing rapid increases in their respective older populations, there is a need for new 21st century visions, practices, cultural sensitivities and evidenced-based policies that assist in balancing the tensions between informal and formal long-term care support and services as well as examining topics about aging.

The **JALTC** is being launched as the official journal of the **NASAG**. The preceding journal aims to foster new scholarship contributions that address theoretical, clinical and practical issues related to aging and long-term care. It is intended that the **JALTC** will be the first and foremost a multidisciplinary and interdisciplinary journal seeking to use research to build quality-based public policies for long-term health care for older people.

It is accepted that aging and long-term care is open to a diverse range of interpretations which in turn creates a differential set of implications for research, policy, and practice. As a consequence, the focus of the journal will be to include the full gamut of health, family, and social services that are available in the home and the wider community to assist those older people who have or are losing the capacity to fully care for themselves. The adoption of a broader view of aging and long-term care allows for a continuum of care support and service systems that include home base family and nursing care, respite day care centers, hospital and hospice care, residential care, and rehabilitation services. It is also crucial to be aware that life circumstances can change suddenly and dramatically resulting in the need for transitional care arrangements requiring responsive, available, accessible, affordable and flexible health care service provision.

For further assistance and more detailed information about the JALTC and the publishing process, please do not hesitate to contact Editor-in-Chief of the JALTC via sending an e-mail: editor-in-chief@jaltc.net
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